EXHIBIT 5

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

- - -

IN RE: C. R. BARD, INC., PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	:	MDL NO. 2187
THIS DOCUMENT RELATES TO	:	
Becky Smith and Donald Mackie, Plaintiffs, v. C. R. BARD, INC. Defendant.	:	Case No. 2:15-cv-16402

- - -

JULY 29, 2019

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Videotape deposition of DANIEL S. ELLIOTT, MD, taken pursuant to notice, was held at the law offices of Reed Smith LLP, 136 Main Street, Suite 250, Princeton Forrestal Village, Princeton, New Jersey 08540, beginning at 1:27 p.m., on the above date, before Amanda Dee Maslynsky-Miller, a Certified Realtime Reporter in and for the State of New Jersey.

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ALSO PRESENT:
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DEPOSITION SUPPORT INDEX

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Direction to Witness Not to Answer
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None

Request for Production of Documents
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None

Stipulations
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Question Marked
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None

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(It is hereby stipulated and agreed by and among counsel that sealing, filing and certification are waived; and that all objections, except as to the form of the question, will be reserved until the time of trial.)

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VIDEO TECHNICIAN: We are now on the record. My name is Dan Lawlor, I'm a videographer with Golkow Litigation Services. Today's date is July 29th, 2019, and the time is 1:27 p.m.

This video deposition is being held in Princeton, New Jersey, in the Matter of Becky Smith versus C.R. Bard, Inc., Pelvic Mesh. The deponent is Daniel Elliott. Counsel will be noted on the stenographic record.

The court reporter is Amanda Miller and will now swear in the

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witness.

- - -

DANIEL S. ELLIOTT, MD, after having been duly sworn, was examined and testified as follows:

- - -

VIDEO TECHNICIAN: Please proceed.

- - -

EXAMINATION

- - -

BY MR. BUHR:

Q. Good afternoon, Doctor. My name is Eric Buhr, I represent the defendant in this case.

Can you please state your full name for the record?

A. Daniel Stephen Elliott.

Q. And you understand you're here today as a retained expert for Becky Smith in her case against C.R. Bard?

A. Correct.

Q. Is there any reason you cannot understand and answer my questions

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to the best of your ability today?

A. As long as they're stated clearly, no.

Yes.

Q. Fair enough.

You've been deposed several times in the past; is that right?

A. Correct.

Q. You feel comfortable with the deposition process and the rules we typically like to follow?

A. Yes.

Q. So I won't go over the typical admonitions, then.

But I will say that with the video conference here with the slight delay, make a special effort, and I'll do the same, to let each other finish and not talk over each other for the sake of the court reporter and just understanding each other.

Is that fair?

A. Yes, it is.

Q. Let's start with just

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housekeeping and attach as Exhibit A a copy of the deposition notice.

- - -

(Whereupon, Exhibit Elliott-1, Notice of Videotaped Deposition of Dr. Daniel S. Elliott, was marked for identification.)

- - -

BY MR. BUHR:

Q. Doctor, have you seen this deposition notice before today?

A. Yes, I have.

Q. It includes a long list of document requests. And I won't go through each one of them.

I understand from our discussion off the record that you've already produced most or all of the records that would be responsive, except, perhaps, invoices regarding this case.

Is that a correct understanding?

A. That is what I understand as

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well.
Q. So just to be clear, you haven't brought anything with you?
A. No.
You cut out on us a little bit. I think I understood your question, but there was a little bit of a gap there. You may just want to repeat it so I know.
Q. Just to be clear, you didn't bring anything with you today to produce?
A. That is correct, I did not bring anything.
Q. You've been retained on behalf of Wagstaff Cartmell to provide expert testimony in this case; is that right?
A. Correct.
Q. And you previously provided expert reports and provided expert testimony in this MDL against C.R. Bard; is that right?
A. Correct.
Q. And, in fact, you previously

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provided a generic report on the involved products and were deposed on those generic opinions; is that right?
A. Correct. Several years ago, yes.
Q. So we'll try not to tread any old ground on those generic opinions.
So today we're specifically discussing your opinions regarding Becky Smith. Is that consistent with your understanding?
A. Yes, exactly.
Q. Do you recall when you were first retained by the Wagstaff firm to provide expert opinion in Bard cases?
A. I don't recall the exact time. I know I gave a general report and deposition four, five years ago. But I don't have the exact timeframe of that, though.
Q. Do you know how many Bard cases you have provided expert opinion in?
A. Off the top of my head,

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without a -- I would say three or four perhaps.
Q. Do you know the total amount of time that you've spent in this litigation against Bard?
MS. SCARCELLO: Object to the extent it calls for testimony about general opinions.
THE WITNESS: No, I don't. I don't have that number.
BY MR. BUHR:
Q. Do you have any general estimate of the amount of hours you spent on the C.R. Bard cases?
MS. SCARCELLO: Same objection.
THE WITNESS: I don't keep any record.
BY MR. BUHR:
Q. You don't keep invoices that you submitted to the Wagstaff firm?
A. No, I do not.
Q. And am I correct that you charge $700 per hour for case review and

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testimony?
A. Correct.
Q. Am I correct that you've also provided expert testimony in a number of pelvic mesh cases against Ethicon?
A. Correct.
Q. And are you retained through the Wagstaff firm for those cases as well?
A. Yes.
Q. Do you recall approximately how many Ethicon cases you've provided expert testimony in?
A. I don't have an exact number. The majority of the work would be done with Ethicon as opposed to Bard, though.
Q. Have you provided expert testimony in any other pelvic mesh litigation other than Ethicon and C.R. Bard?
A. There was work done early on against -- with the Cook product, which

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is a non-mesh. And then a little bit of work with the AMS products. I don't know how far those extended, but I didn't do any patient case-specific reviews, and I do not believe I turned in any general expert report. But I looked at issues originally.

Q. Do you have any estimate for how much time you spent specifically on the Becky Smith case?

A. I don't have an exact number. That work was done in May of this year and sent to the Wagstaff firm. So they have that, which I've been told will be provided to you.

Generally, they take several hours or more. But I don't have a specific recollection of this one.

Q. So when you say "they have that," are you referring to an invoice for your time?

A. That is correct.

MR. BUHR: And then, counsel, I know we mentioned this

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prior to the deposition, but for the record, you'll agree to produce those to our offices, whatever invoices you have specific to this Becky Smith case?

MS. SCARCELLO: Yes.

BY MR. BUHR:

Q. Have you spent additional time since the submission of those invoices, or invoice, around the May timeframe?

Do you have an estimate for how much additional time, if any, you've spent on this case?

A. It's been several hours spent this month alone. So since May, there's been none until this month, July. And, again, that would be several hours reviewing depositions and expert reports.

Q. So, then, would it be approximately six hours you spent in total on this case, if I'm understanding what you said, in your time spent in May and your time spent in July?

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MS. SCARCELLO: Object to the form of the question.

THE WITNESS: I would just -- I would have to be guessing, because I have not seen that May invoice. I would suspect the May invoice would be around the four- to seven-hour range. Again, that's very much of a guess.

And then in July, it's around the same amount of time.

BY MR. BUHR:

Q. I assume you haven't submitted your -- an invoice for your July time; is that right?

A. That's correct. That will be done at the end of the month. So in a few days.

MR. BUHR: Let's go ahead and attach your case-specific expert report as Exhibit-2, I believe it would be.

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(Whereupon, Exhibit Elliott-2, Case-Specific Expert Report, was marked for identification.)

- - -

BY MR. BUHR:

Q. So what we've attached as Exhibit-2, does that appear to be your complete expert report in this case?

A. It appears to be signed and dated May 24th, 2019. It includes my report, my -- and my C.V. and my reliance list.

Q. And does this report contain all of the opinions that you intend to offer in this case specific to Becky Smith?

A. Up to this point, yes. If new material becomes available, obviously, that would change. But as of today, July 29th, this is complete.

Q. And can you generally describe for me how you go about forming your opinions?

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A. Forming my opinions on this case or anything I do in my normal daily work would be the same. It would be reviewing the outside medical records, talking with the patient usually, though in this case I can't talk to her, obviously, and based upon my experience, my review of the medical literature, discussions with colleagues, et cetera, come up with an opinion ruling in or ruling out various different pathologies.

Q. And so Exhibit B to your expert report is your reliance list.

And that's everything you relied on in forming your opinions at the time of your expert report, correct?

A. Correct.

Q. And how did you go about compiling these materials?

A. As part of my usual, I ask whatever law firm it happens to be, this time, obviously, it's Wagstaff and Cartmell, give me all medical records that are available, all depositions, all

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expert reports, everything. And then I review whatever they give me.

Q. Did you feel you had adequate materials to form your opinion at that time?

A. Yeah, at that time. Yes. There's been added on since that time, with depositions of the implanting doctor and one of the revision surgeons, and then the -- what would you call it? The defense expert witness. I've reviewed that since then.

Q. What do you mean by --

A. But my opinions did not -- Sorry, go ahead.

Q. I didn't want to cut you off if you were still finishing your answer.

A. I was going to finish by saying the reviewing of those further documents, the deposition and expert report did not change my opinions significantly, it mainly supported them.

Q. Did you request any additional medical records?

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A. Well, I request all medical records that are available. And so I'm at the mercy of the law firm of giving me whatever they can get ahold of.

If I find an operative note or something that I don't have, I ask them for it. But that wasn't in this particular case. So as far as I know, I've been given all of the records.

Q. And you kind of alluded to this a little bit already, but just to be clear, at the time you formed your opinions and signed your report, you didn't have the depositions of any of the treating physicians in this case; is that right?

A. That is correct.

Q. And did you feel that you could form your opinions without the testimony of the implanting and explanting physicians?

A. I can essentially form my opinions based upon the medical records, and then augment that with the

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deposition.

Had the depositions shown a significant opinion difference or changed my opinion one way or the other significantly, then I would have asked for a supplemental report to be filed.

Q. So several times, I believe, you used the term "significantly."

Did reviewing those depositions after your expert report change your opinions in any way?

A. No, they just reinforced them. So it didn't change. Reinforced.

Q. Did you review the entirety of those depositions or just excerpts?

A. No, as per my usual, I asked for the entire deposition, all however-many-hundreds of pages they are, and then I go through them. So I do not get ever a summary.

Q. Do you get a summary, any type of summary, of the medical records, or do you review those in their entirety as well?

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A. I review them in their entirety. I found that chronologies as provided, they weren't provided in this case, but if they are provided, they tended to not be very accurate. So I did it all myself, every single page.
Q. So, then, just to be clear, even though you reviewed additional materials since you signed your expert report, you still feel it's complete and accurate?
A. Yes.
Q. And it contains all of the opinions you intend to offer and your basis for those opinions?
A. As I stated before, unless new information were to be provided that's not available as of July 29th, 2019. But right now it is complete.
Q. I believe you mentioned reviewing an expert report from the defense.
What specifically are you referring to?

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A. There was a Dr. -- I won't pronounce his name correctly, so I have to apologize -- Guidice, Guidice, something like that.
Q. I say Guidice, but I don't know if that's correct either, to be honest.
So you reviewed his report?
A. Correct.
Q. Did you have any significant disagreements with his report?
A. Yeah, that's a -- we'd have to go through point by point of his report. But, yes, I have some major disagreements.
Q. Did you do anything to specifically prepare for the deposition today?
A. Other than just on my own, reviewing my expert report, as I said -- mentioned earlier, reviewing the depositions from the two physicians and then the expert report, Dr. Guidice, and I had a 15-minute meeting with counsel

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this afternoon.
Q. You had a 15-minute meeting with counsel today?
A. Correct.
Q. And was that with the counsel that's here at the deposition today?
A. Correct.
Q. There was also a subsequent deposition of plaintiff Becky Smith that took place maybe a month and-a-half ago.
Did you review that deposition transcript?
A. I have not seen that one.
Q. So the only deposition of the plaintiff that you've reviewed is the deposition that took place in 2017; is that right?
A. Correct.
Q. Is that something you would like to review, her new deposition?
A. Yes.
Q. And you have not personally examined Becky Smith; is that right?

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A. Correct.
Q. I believe in some prior Bard cases you performed examinations, what we sometimes refer to as an IME.
Do you recall that?
A. Yes.
Q. And why did you not do an IME or any type of examination with Becky Smith?
A. I was under the understanding that there was an agreement that if this case, or whatever you call it, were to proceed forward, then I would do one prior to any trial case.
Q. So is that something you think would be helpful in forming your opinions?
A. Yes.
Q. Have you spoken with Becky Smith?
A. No.
Q. Have you spoken with any of her doctors?
A. No.

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Q. Can you describe generally for me your method in drafting this expert report?
A. It would be the same as all reports I do. I review all of the medical records, write down a chronology with key comments made within the records. From there, formulate a differential diagnosis ruling in or ruling out various different pathologies.
And then I write the report up and then come to conclusions, based upon the information I had at that point in time.
Q. So would you personally take notes as you're reviewing the medical records?
A. No. I do it -- as I go, I write it. So there's no separate set of notes.
Q. And does the report contain everything you ruled in and ruled out in your differential diagnosis?
A. Correct. As what is

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indicated on Page 4 of my report going to Page 5, that would be my standard differential diagnosis.
Q. Did you have any assistance preparing your report?
A. None.
Other than the reliance list. Sorry, I should -- I did not type up the reliance list. I typed up the medical billing records, the depositions and then the Wagstaff firm provided the other. So I did not personally type that up.
Q. I'd like to attach, just for the record, your list of previous testimony that was provided to us. This wasn't attached to your expert report, it was provided to us separately.
MR. BUHR: So I just want to make sure it was attached for the record. Let's do it as Exhibit-3.
- - -
(Whereupon, Exhibit Elliott-3, List of Previous

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Witness Testimony, was marked for identification.)
- - -
BY MR. BUHR:
Q. So is this an accurate list of your previous testimony?
A. Well, I don't keep a list of my testimony, so this would have come from the Cartmell firm. So I cannot attest to the accuracy or completeness of it.
It looks fairly complete. But, again, I don't -- in retrospect, can't say if it's complete.
Q. Can you tell by looking at it what time period this covers?
A. It would cover roughly 2011 to the present.
Q. Does it appear to be roughly in chronological order, to the best you can tell?
A. Well, the very first one says Coloplast versus Generical Medical Devices and the very last one is the same

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thing. So, I don't know, it says, In regards to Mentor ObTape, that was -- wait, I'm sorry, that's different.
I would have to say, yes, it does look accurate. I just don't know why that Mentor -- the last one is Mentor ObTape. I don't know how that fits in there. But it looks fairly accurate.
Q. Do you recall roughly when you last testified?
A. Well, "testified," do you mean -- does that mean a deposition?
Q. Yes.
A. Or a trial, in the courtroom?
Q. Either one.
A. Last deposition I gave was last weekend. Last time I was in a courtroom was February of 2018.
Q. Is your deposition last weekend listed on this report?
A. No.
Q. So what case was that in?
A. That was a deposition --

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case-specific depositions on three Bard cases -- excuse me, three Ethicon cases and one Bard case.
Q. What was the product at issue in the Bard case?
A. Avaulta. And the individual also had an AMS sling, but that was not part of the deposition.
Q. And what were the Ethicon products involved in those cases?
A. Two Prolift?s and one TVT-O.
Q. Is the Prolift? a product to treat pelvic organ prolapse?
A. Correct.
Q. And the TVT-O is a pelvic mesh product to treat stress urinary incontinence?
A. Correct.
Q. And you provided expert opinion that those products were defective and caused injury; would that be right?
A. Correct.
Q. And with respect to your

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courtroom testimony in February 2018, do you recall what case that was and what it involved?
A. It was a Prolift? case with Wagstaff Cartmell in Indiana, if that helps.
Q. Are there additional Ethicon products that you provided expert opinion on?
A. TVT as well, and TVT-Secur.
Q. And your opinion is all those products were defective and caused injury?
A. Correct.
MS. GRIFFIN: Eric, just for the record, that came in a little spotty, in case you want to repeat that.
MR. BUHR: Thank you for that.
BY MR. BUHR:
Q. So you provided expert opinion that all the products you just listed from Ethicon were defective and

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caused injury; is that right?
A. Correct.
Q. So turning more specifically to Becky Smith, you referenced your general differential diagnosis list on Pages 4 and 5 of your report, correct?
A. Yes.
Q. And you were able to rule all of those out as potentiality alternative causes?
A. Well, no, I don't rule them all out, because some of those include mesh complications. So some of them are ruled in, some of them are ruled out. The majority are ruled out.
Q. So you ruled out everything other than those related to mesh?
A. Well, we would have to go -- sure, I don't want to make a blanket statement and miss something here, but either mesh or mesh-specific complications, yes, I ruled them out.
Q. So just to be clear as a starting point, that I understand the

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opinions that you intend to offer here, with respect to Becky Smith's specific injuries, am I correct that you're offering an opinion that the Bard mesh implants caused plaintiff, Becky Smith, pelvic pain and dyspareunia and mesh extrusion?
A. As summarized on Page 18 of my report, starting on Page 18, yes, pelvic pain, vaginal pain and dyspareunia resulting from the complications caused by the presence of the mesh in her body.
Q. So just to be clear, you're not offering an opinion that she has any other injuries such as voiding dysfunction or anything like that, right?
A. Well, voiding dysfunction can be caused by the presence of the mesh, the removal of the mesh, or dysfunction caused by. So we would have to be very specific.
From what I understand, as of now she was not complaining of significant voiding dysfunction. But if

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you had something, I'd have to see it in the records. I didn't see that.
Q. Well, I didn't see anything either. I just want to make sure that what you're alleging her injuries are related to the mesh is encompassed by pelvic pain, dyspareunia and extrusion requiring removal of the mesh, correct?
A. Correct. As of right now, yes.
Q. You're aware that plaintiff has complained of fecal incontinence; is that right?
A. Yes.
Q. And you're not offering an opinion that that was caused by the mesh; is that right?
A. As of what I know right now, it is very difficult to draw a logical physiologic relationship between the presence or absence of the mesh or surgery for the mesh causing fecal incontinence.
Q. So you are not offering an

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opinion that her fecal incontinence was caused by the mesh?
A. Well, as I stated, as of what I know right now, I cannot draw a logical connection between the mesh and the surgery to remove the mesh with fecal incontinence.
Q. And you would agree that plaintiff's treating physician, Dr. Denman, also concluded that the -- her fecal incontinence was not related to the mesh; is that right?
A. Yes.
Q. Is it your opinion that both the Avaulta and the Align are responsible for her injuries?
A. They are both contributing.
Q. Can you say what percentage of her injuries are related to the Avaulta versus the Align?
A. It's very difficult to assign a percentage. However, due to the significantly enlarged volume of the Avaulta mesh, the multiple arms and the

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collagen coating, it is going to be more responsible than the TVT-O -- excuse me, the Align.
Q. But you intend to offer an opinion that the Align is responsible for her pelvic pain and dyspareunia?
A. It will be a contributing factor. Since the mesh is identical and it's going in the same obturator foramen, it is not going to be helping any.
What I'm saying is, I cannot assign a percentage. More likely, the Avaulta is going to be the much greater percentage, just, as I mentioned, due to the volume and the presence of the collagen coating.
Q. And you're saying that the mesh of the Align and the Avaulta are identical?
MS. SCARCELLO: Object to the form.
THE WITNESS: No, they are not identical. The meshes are quite similar. But the Align does

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not have a collagen coating like the Avaulta Plus, which Ms. Smith has, or had.
BY MR. BUHR:
Q. Are you offering an opinion that the extrusion was related to the Align product as opposed to the Avaulta?
A. From what I understand at this point, the Avaulta product was the product that had extruded, not the Align.
Q. I understand, from your prior testimony -- well, let me confirm if my understanding is correct.
Have you ever implanted a transvaginal mesh for pelvic organ prolapse?
A. No. I have chosen not to do that.
Q. Have you implanted midurethral slings made out of polypropylene?
A. Yes.
Q. Have you ever implanted the Align?

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A. No.
Q. What midurethral slings have you implanted?
A. I've gone through a series of them and had problems, and that's why there's been a series.
I started with the Mentor ObTape in the early 2000s, probably 2002 or '03, around that time. We obviously had major problems with that. Then I switched to the AMS product called the Monarc, used that for a couple of years. But we had a significant amount of problems of pain for the patient for that, so I stopped that. And then used the Coloplast product, their transobturator sling.
Q. And is that made of polypropylene?
A. Correct.
Q. And it's implanted transobturally -- through the transobturator, sorry, similar to the Align sling; is that right?

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A. Correct. It's a transobturator sling, correct.
Q. And would you agree that all of those products have a risk of pelvic pain and dyspareunia?
A. All the mesh slings, to a varying degree, have a problem with dyspareunia, scarring, mesh contraction, foreign body reaction; so yes.
Q. And that includes the Coloplast sling?
A. Correct.
Q. And you still implant that today?
A. Very rarely. I used to, and then as of 2011 or so, the numbers plummeted to one or two a year from a high of about 100 to 150. And now there's maybe a few a year I do. I can't give you an exact number, roughly 5 out of 100 a year for unique patient situations.
Q. Do you agree that the midurethral slings made of polypropylene

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are within the standard of care?
A. In the properly consented patient and with a surgeon who knows what they're doing and can handle the complications, it is within the standard of care.
Q. Are they generally considered safe and effective in the medical community?
A. The general community? I can't speak for everybody. But there have been position statements making that, that's what they state.
Q. Are you referring to the AUGS position statement?
A. That's one of them.
Q. Are you a member of AUGS?
A. Yes.
Q. Do you agree with that position statement?
A. I agree that it has been the -- that statement is long, with multiple points to it. So I can't give a blanket yes or no to it. We'd have to go

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through each point.
But I agree it has been studied, and I agree that there have been advances with that product. But there have also been significant complications associated with it. And that's where the problem occurs with me.
Q. So at the time of Ms. Smith's implant in 2008, you agree it was within the standard of care for Dr. Kim to implant the Align midurethral sling to treat her stress urinary incontinence; is that right?
A. Correct. I have no fault with Dr. Kim for implanting that at that point in time.
Q. Right. And one of the opinions listed in your report is that the treating doctor, including Dr. Kim, acted within the standard of care.
Is that an opinion that you intend to offer?
A. Yes, I agree with that, in 2008 when it was put in.

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Q. Do you also agree that it was within the standard of care in 2008 to implant mesh for treatment of pelvic organ prolapse?
A. Correct. As of January of 2008, I agree that was within the standard of care.
Q. So you agree it was within the standard of care to implant the Avaulta Plus in 2008?
A. Well, in 2008, we were in our very infancy of knowing what was going on with meshes. I had chosen not to implant meshes, I didn't see a benefit for them, but I didn't feel they would be wrong. We were seeing increases in complications slowly rolling in.
But as of January 2008, when that was implanted, I would find no fault in that, it was within the standard of care. So I agree with what I've stated in my report.
Q. Would it be within the standard of care to implant mesh to treat

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pelvic organ prolapse -- well, strike that.
Would it be within the standard of care in 2008 to implant the Avaulta Plus if the patient did not have pelvic organ prolapse?
A. Well, it is -- the Avaulta or the Avaulta Plus, Avaulta Solo, is defined for prolapse. If a woman has absolutely no prolapse, you would not want to implant it, because it's designed to treat prolapse.
Q. What if the patient had a mild prolapse but was asymptomatic, would it be within the standard of care to implant the Avaulta mesh?
A. That becomes a judgment call. That one has to be a discussion with the patient. If you are going in to operate already for another indication, and they have a low-grade prolapse, it depends what grade you're talking, we have to use specifics.
Technically, for the female

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pelvic mesh and reconstructive surgery exam, if you have a grade 2 and above, it's acceptable to treat. But it has to be a discussion with the patient.
Q. The doctor that performed a hysterectomy at the same time the mesh was implanted was Dr. Crawford; is that right?
A. Correct.
Q. Were you aware that Dr. Crawford found that Becky Smith did not have any significant cystocele?
A. That's what I've heard, yes.
MR. BUHR: And let's just go ahead and attach that record as Exhibit-4, just to make sure we're looking at the specifics.
- - -
(Whereupon, Exhibit Elliott-4, 11/15/07 Dr. Julie Crawford Medical Note, was marked for identification.)
- - -
BY MR. BUHR:

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Q. Do you have that record in front of you, Doctor?
A. Yes, I do. I have, as you said, Exhibit-4. And this is dated November 15th, 2007. It's a note by Dr. Kim -- no, I'm sorry, Dr. Crawford, Julie Crawford.
Q. And if you turn to -- well, before we get there. On Page Bates number 8, they list the past surgical history.
Number 2 is, Prior bilateral tubal ligation.
Can you explain what that is?
A. That's for -- most likely, for sterility. So they ligate the tubes, analogous to a vasectomy in a male. It was done laparoscopically.
Q. Is that a procedure that can lead to any type of pelvic pain or dyspareunia?
A. It would be exceedingly rare. That's a small procedure done

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laparoscopically with small cameras. So I'm sure we can find a case report here or there, but this would be an exceedingly small risk.

Q. Is it possible to develop adhesions following that type of procedure?

A. Adhesions could happen up in the abdomen.

Q. And adhesions are essentially scar tissue, right?

A. They are a type of scar tissue.

Q. And they can lead to pain?

A. There have been reports of that, yes.

Q. Is this something you considered in your differential diagnosis of Becky Smith's pelvic pain and dyspareunia?

A. Correct. And prior to her surgery, her implant surgery on January 15th, 2008, I did not see any record of pelvic pain.

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Q. So you ruled it out because she didn't complain of any pelvic pain at that time?

A. Correct. Following the surgery, adhesions, et cetera, you're going to have -- it's not a delayed development like we see in the meshes; it's immediate. And there's no record of anybody attributing any abdominal pain, pelvic pain, attributing it to any adhesions.

If you have those records, I'd like to see it. I did not see anything in the records.

Q. They also list a 2003 endometrial ablation.

Can you describe for the jury what that is?

A. Well, that falls definitely into the benign GYN land, which I do not do these procedures. Usually, this is done for uterine fibroids; usually. And it's to help reduce the severity or bleeding, abnormal bleeding, caused by

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the fibroids.

Q. Are you familiar with the potential complications from that type of procedure?

A. I do not do that procedure, but I am familiar with the types of pain that they could have. Same thing with fibroids.

And, again, as I mentioned before, I didn't see anything documented in the records attributing any of her conditions, prior to her 2008 surgery, to procedures such as that.

Q. Under medications, she's taking Lexapro.

And I think you note in your record that she had preexisting depression prior to the implant meshes, right?

A. Correct.

Q. Going on to the next page, Dr. Crawford performed an exam, right?

A. Correct. Starting on the Bates number 8 going to, it looks like,

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just 9.

Q. And the vaginal exam notes, No evidence of a significant cystocele or rectocele, appears well supported.

Is that right?

A. That is what she states as of November 15th, 2007.

Q. And that was just a month prior to her implant surgery, right?

A. Well, technically, like two and-a-half months. But it was close. Because her surgery was -- actually, it was, like, two months.

Not to be difficult, just for specifics here. January 15, '08 was her surgery.

Q. You're right.

So about two months prior to her surgery, Dr. Crawford did not find any evidence of a significant cystocele or rectocele?

A. Correct. On her exam on that day, that's what she reported.

Q. And then she sees Dr. Kim a

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few weeks later, on November 30th.
MR. BUHR: And let's go ahead and attach Dr. Kim's records as Exhibit-5.
- - -
(Whereupon, Exhibit Elliott-5, 11/20/17 Dr. Kim Medical Record, was marked for identification.)
- - -
BY MR. BUHR:
Q. Do you have those records in front of you now, Doctor?
A. Yes, I do.
Q. So on Page -- if you go to Page 12 and 13 of the Bates numbers, this is the visit with Dr. Kim on November 30th, 2007.
A. Correct.
Q. And under assessment -- actually, under examination, it says she does have a grade 1 to 2 cystocele and a mild rectocele.
Do you see that?

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A. Yes, I do.
Q. And what symptoms can cystocele and rectocele cause?
A. Fullness, pressure, sensation of something falling out; asymptomatic, retention of urine, retention of stool.
Again, I think I mentioned pelvic pressure. Symptoms such as that, or those.
Q. Prolapse can cause pelvic pain and dyspareunia, too, right?
A. Well, pelvic pain, not necessarily. Pelvic pain would be different.
Pelvic pressure can -- it can interfere with sexual activity, depending upon the severity of the prolapse. They should be very specific.
Pelvic pain is not something we normally attribute, unless it's a major, major prolapse where the vagina has everted itself and it's irritating on the clothing and things.

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Q. And Dr. Kim did not repair the mild rectocele, right?
A. Correct.
Q. So would you agree that the grade 1 to 2 cystocele is a mild cystocele?
A. Grade 1 is mild. Grade 2 is not. It's in the realm of more significant. And prolapses vary from day-to-day depending how the woman is, the time of day, how much standing they have been doing. So it's not uncommon to have a variable exam.
Q. Going back to Dr. Crawford's records --
MR. BUHR: Actually, do we have her January 10th, 2008 record?
MS. GRIFFIN: We do. And that can be marked as Exhibit Number 6.
- - -
(Whereupon, Exhibit Elliott-6, 1/10/08 Dr. Julie

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Crawford Medical Record, was marked for identification.)
- - -
BY MR. BUHR:
Q. Do you have that record, Doctor?
A. Yes, I do.
Q. On Bates number ending in 27, under the physical examination, about three or four sentences above the end of that paragraph, it says, On my exam, there is no evidence of significant cystocele or rectocele and she appears apically supported. However, on exam by Dr. Kim, she has a mild rectocele and cystocele.
Do you see that language?
A. Yes, I do.
Q. So do you have any criticism of implanting the Avaulta product in a patient with only mild cystocele and is asymptomatic?
A. I have criticism of implanting the Avaulta product. However,

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on Dr. Kim's examination, grade 1 is low, grade 2 is acceptable. And so that becomes a judgment call by the doctor who is there. And, as I mentioned, prolapses vary from day-to-day.

If I were operating with a doctor who I felt was doing something wrong, I wouldn't operate with him. I wouldn't do a combined case. Dr. Crawford just mentions it, so I don't have a criticism, really. If it were only a grade 1, that would be different. But it reports grade 2.

Q. And you agree she was asymptomatic at this time with respect to her cystocele?

A. I didn't see anything in the records indicating significant prolapse symptoms.

But they were going to be doing an anti-incontinence procedure, so it's quite common to do a combined repair when you're doing that, because otherwise it will affect your incontinence

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procedure.

Q. So you stand by your opinion that Dr. Kim acted within the standard of care?

A. I would -- if I were in the same situation, I would not have done an Avaulta product. I would have done the anterior repair at the time of the sling surgery.

Because when you're repairing incontinence, if you don't repair concurrent prolapse, if you find a grade 2, that can affect your repair. So it's not uncommon to do a prophylactic either incontinence procedure or a prolapse repair.

If Dr. Kim had repaired the posterior, I would have a major problem with that. But anterior compartment, it's a judgment call, so I don't criticize it.

Q. Would you agree that there are risks associated with any implanted product?

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A. Well, it depends what type of implanted product we're talking about, and the severity and the progressive nature of them can vary tremendously. But procedures do have risks.

Q. And we talked about some of the other transvaginal mesh products where you provided specific opinions in other litigation.

Would you agree that all transvaginal mesh products for pelvic organ prolapse and stress urinary incontinence have risks?

A. So I just want to make sure I heard your question correctly.

You stated all pelvic organ meshes for prolapse and slings have risks; is that -- am I correct?

Q. Yes, essentially.

A. Okay.

Yes. To varying degrees, yes, they do.

Q. And they all have the risk of extrusion, pelvic pain and

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dyspareunia?

A. Yes, to varying degrees; as long as we're still talking about pelvic organ meshes and slings, they all do to varying degrees.

Q. Would you agree that these are common and well-known risks?

A. I agree that they are common. I disagree that they are well known, the true incidence is not usually disclosed. It is becoming much more well known since 2011.

Q. And if I understand your report correctly, you intend to offer an opinion that Dr. Kim was not advised of all the potential risks?

A. What I'm saying is as far as the level of disclosure of the known risks with the Avaulta, the Avaulta Plus, and the Align, that was not fully disclosed, so Dr. Kim would not be able to know those full risks, as I do, having read internal documents, e-mails, et cetera, as outlined in my general report.

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Q. Would you agree that Dr. Kim is the better authority on what she knows and what she doesn't know?

A. No. She knows only what she knows, but she doesn't know what I know.

And important -- an important part of that is, I've had a chance to review internal documents, which I'm under a confidentiality agreement, so I can't discuss that, even with my own colleagues, I can't discuss -- or, I don't know if I can discuss it so I don't. So they don't know what was known at the launch of the product and everything.

Dr. Kim knows everything she knows. But, again, she doesn't know what else there is out there to know. The old phrase "you don't know what you don't know" type of thing. That's very confusing, however, it's very accurate.

Q. She may not know everything that you know, and it's equally true that you may not know everything that she

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knows; is that fair?

A. Yes, to a certain extent. I have an advantage of being at a large teaching institution, attend meetings nationally, internationally, speak on this subject, and have read internal documents from, essentially, all of the producers of meshes.

There is the chance she knows something I don't. This is not a criticism of her by any means, but that's unlikely. So I am playing the overwhelming odds I have -- I've had an opportunity to know and learn more than she has.

But, again, that's not a criticism of her, by any means.

Q. I guess the point I'm trying to get at is, if she says that she's aware of the risk of extrusion, you're not in a position to disagree with her; is that fair?

A. We would have to ask her what percentage. It's a vague, are you

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aware of the risk of a fuel pump going out in a Mustang? Well, I don't know, I think I do.

But specifics. Is she going to be able to say, yeah, it's 12 to 22 percent, based upon e-mails that we've seen from internal documents; or is she going to go on the literature or is she going to go off the IFU, which doesn't tell us any risks?

So we would have to ask her specifically, what are -- what percentage of individuals have mesh contraction, extrusion, et cetera, progressive nature. And if she gave me a percentage, then I would be more likely to agree or disagree with your comment.

Q. So is it your position that she can't understand the risks of the product sufficiently if she doesn't know the exact percentage of every potential risk?

MS. SCARCELLO: Objection to form.

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THE WITNESS: Yeah. With patients, I feel we have an obligation to tell them, you have a 1 in 5 percent risk of X, Y or Z complication.

The word significant, minor, rare, don't mean anything to an individual patient. That's been studied; that's, you know, in some of my reports. I think we have to give numbers to those.

So Dr. Kim has a good education, I don't doubt anything like that. But, again, I just don't think she -- she never had a chance to know all that could go wrong with the product.

BY MR. BUHR:

Q. Did you read her deposition testimony when she talked about her knowledge of the risks?

A. Yes.

Q. Do you agree that she testified she was aware of the risk of

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extrusion?
A. Yes. And I also know that a doctor is not going to tell you that they did not know, because they're opening themselves up. So I agree that's what she stated.
Q. And she also testified that she was aware of the risk of chronic pelvic pain at the time she implanted these products?
A. Correct, that's what she stated.
Q. And she also testified that she was aware of the risk of chronic dyspareunia associated with these products at the time she implanted them in Ms. Smith?
A. That is -- that is what she states.
Q. If Plaintiff would have received a different transvaginal mesh product, would you agree that she still may have had pelvic pain and dyspareunia?
MS. SCARCELLO: Object to

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form.
THE WITNESS: Well, as I've stated before, the various different mesh products all have different sets of complications, depending upon the composition of the mesh, plus or minus having a collagen -- or a, excuse me, a protein coat to them.
But there is significant level of risk with all of them.
BY MR. BUHR:
Q. So you're not saying that if she used a different product it would have eliminated her risk of pelvic pain or dyspareunia; is that fair?
A. Well, Avaulta is unique -- the Avaulta Plus, excuse me. It is unique with that extra layer on it, which has never been shown to have any potential benefit.
So I can't state that she would have had more or less with the other ones, but the other ones don't have

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that coating to it. So you're not going to be lowering the risk any.
Q. Would you agree that a hysterectomy can cause pelvic pain and dyspareunia?
A. In specific locations, in varying severity and progressive nature of it, it can be associated with pelvic discomfort.
Q. Is that something you considered in your differential diagnosis?
A. Yes.
Q. Is that listed anywhere in your report as something you considered in your differential diagnosis?
A. When I review the location and the descriptions of the other doctors, and their palpation of mesh contraction, I am going to automatically rule out hysterectomy-related pain, because that's not going to cause -- or be associated with mesh contraction and palpation tenderness.

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Q. Is it possible that some of her pain is related to the hysterectomy?
A. On the anterior vault and obturator space, no.
It's going to be in varying degrees. So I can't completely, 100 percent, rule out everything. I have to look at the data and my experience, and that's what points to the mesh.
Because the vaginal vault discomfort after a hysterectomy is different, it's treated differently. We have different successes with it than with the meshes. So that's why I have to -- we have to look at the totality of the patient for that answer.
Q. And would you agree that nowhere in your report do you discuss the hysterectomy as a possible alternative cause or how you ruled it out?
A. I didn't feel I needed to, because I talk about the specific mesh contraction, mesh exposure, tenderness on palpation on the anterior vault. That's

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away from where the hysterectomy was performed.
So my experience, on a daily basis dealing with women who have had hysterectomies, we don't see discomfort in that region. So we're talking about a different region.
Similar, I don't talk about ovarian pain or ovarian cysts, because it's a different location, different intensity.
So I don't specifically state it that way, and I didn't feel I needed to.
Q. Did you review the consent form from Dr. Kim?
A. Yes. And I have -- I believe, the consent form, I make a reference to on November 30th, 2007. It's on Page 11 of my report, where it states, at the very last sentence -- it's the middle paragraph, very last sentence, and it says, A full PARQ conference was held regarding the procedure.

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Q. Did you review the actual consent form for the operation?
A. I don't recall -- I mean, I reviewed whatever was there. I'd have to go look. I don't recall the specific page. I'd have to look at it.
MR. BUHR: Let's attach as the next exhibit, I think is Exhibit-7, the consent form.
- - -
(Whereupon, Exhibit Elliott-7, 1/11/08 Consent Form, was marked for identification.)
- - -
BY MR. BUHR:
Q. Do you have that in front of you now, Doctor?
A. Yes, I do, dated January 11th, 2008.
Q. And under the risks section, do you agree it discusses the risks of further procedures, pain, scarring, wound problems, sexual dysfunction, dyspareunia, malfunction of implanted

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devices?
Those are all risks included on this form, correct?
A. Yes. This is a generic form. They also have cure cancer, persistent stones. This is just a generic consent, not a specific one.
But they mentioned the things you mentioned. They also talk about impotence, women don't have impotence. And ejaculatory dysfunction. Well, women don't have that either.
So this is just a cookie-cutter form.
Q. But it does include the risks of dyspareunia and pelvic pain that we discussed?
A. With no description of the severity, the progressive nature of it, the inability to cure it. Those things are mentioned in a generic form -- generic fashion, excuse me.
Q. Are you also intending to offer an opinion on the adequacy of the

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IFU warnings?
A. For a general report, not for a case-specific. I don't know how that legal stuff goes. It depends what I'm asked.
The IFU, in my opinion, is incomplete, as we discussed in my general deposition several years ago.
Q. And I don't want to re-tread all that testimony.
But I do want to confirm that specifically related to the alleged injuries by Ms. Smith that it specifically warns of dyspareunia and scarification and contraction and extrusion, correct?
A. Correct. That is stated in there in those words that you use, correct.
Q. And did you see Dr. Kim's testimony that she doesn't rely on instructions for use?
A. Correct.
Q. So you're not going to offer

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an opinion in this case, then, that a different warning on the IFU would have made any difference to Dr. Kim; is that fair?
A. Well, what I state is regardless of what Dr. Kim relied upon, the IFU has to be complete with the severity, the frequency, the inability to cure the problems, et cetera, as known by the company.
Q. Right. But in terms of Becky Smith's specific case, you're not offering an opinion that Dr. Kim would have done anything different if a different warning had been provided?
You have to rely on Dr. Kim for that, right?
A. Well, yeah, you're -- ultimately you're right. I can't state what Dr. Kim would have known.
However, had the IFU been fully complete in the severity, the frequency, the inability to fix the problem, Dr. Kim may have heard about

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that. So I can't speak -- so that would be best addressed to Dr. Kim once she knows all the risks of the procedure.
Q. And did you see her testimony that she had good clinical outcomes implanting both the Align and the Avaulta Plus?
A. I saw that that's what she reported.
Q. And you've never implanted either of these products, correct?
A. I have chosen not to.
Q. Would you agree that Ms. Smith initially healed well following the implant surgery?
A. Correct, as that's what is the usual.
Q. She did not have any extrusion until approximately one year after the implant; is that right?
A. I see, in my records, February 13th, 2008. So you are correct, it's a year and one month later was, I believe, the -- no, excuse me, that's

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incorrect.
It's April of 2008 that I believe the records state the first mesh exposure. So a year and, what, three months, something like that.
Q. Well, that's one of the things I wanted to talk to you about.
Because I think -- so April 9, 2008 is only a few months after the implant surgery, right?
A. You are correct.
Q. And so I think the date on that is wrong, and we'll pull that out in a second.
A. Okay.
Q. So in her follow-up, her first post-op visits with Dr. Kim, everything seemed to be healing properly, right?
A. That is correct.
Q. There was no sign of any mesh extrusion on January 23rd, 2008 or February 13th, 2008, right?
A. That is correct.

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Q. And she was noted to be doing extremely well by Dr. Kim, right?
A. That is correct.
Q. And at this point, the Align had corrected her stress urinary incontinence?
A. In the records, I believe it states something that she's doing very well without any problems. So the answer to that would be yes.
Q. And the Avaulta had corrected her cystocele?
A. Correct. Completely gone is what Dr. Kim notes on February 13th of 2008.
Q. On what date? I'm sorry.
A. February 13th, 2008, cystocele, quote/unquote, what I have down here is, completely gone. That's on Page 13 of my report.
Q. Right.
And on that date, and I think it's part of, if you wanted to turn to the records, part of Exhibit-5, and

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Dr. Kim notes that the anterior vaginal wall has healed very nicely; is that right?
A. I don't have those records. But that's, from my recollection, correct.
Q. Then turning to this April 9th, 2008 note that you have of possible mesh extrusion. And that would be on Exhibit-5, ending in Bates number 11.
MS. SCARCELLO: Exhibit-5.
THE WITNESS: I'm sorry, Exhibit-5. I thought you were going to hand me something, turns out I already have it.
You said Exhibit-5?
MR. BUHR: Yes.
THE WITNESS: Okay, I'm sorry. And then Bates number?
MR. BUHR: 11.
THE WITNESS: Okay, I'm there.
BY MR. BUHR:
Q. So is this the record you're

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referring to in your report for April 9th, 2008?
A. Correct.
Q. Is it possible that that handwritten date is actually January 19th, 2008 -- or 2009, rather, and that it was a mistake that's often made in January by writing the prior year, 2008?
A. So you're saying --
Q. 1/19 instead of 4/9?
A. I'm not a, what do you call it, writer expert. I'm just looking at it. I see a 4 and then a 1 with a little slash up, 9, and the slash and up again, 08.
To me it looks like 4/1 -- I mean, we can't be definitive. But, I mean, it looks like my date of April 9th, and you're telling -- you're suggesting what again? 1 --
Q. 1/19 and that they mistakenly wrote 2008 instead of 2009?
A. Well, I -- I don't want to be difficult. To me, it looks like a

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4/1/9 -- I mean, I don't know. If we did 1 --
Q. And I think we do have another copy of this that was in the hospital records.
MR. BUHR: Can we attach it as the next exhibit? Is that Exhibit-8, then?
MS. GRIFFIN: Correct.
- - -
(Whereupon, Exhibit Elliott-8, Hospital Record, was marked for identification.)
- - -
THE WITNESS: If you look down in the history of present illness, 49-year-old female underwent cystocele/Avaulta repair, 1/15/08. Now with mesh extrusion.
So, I mean, it -- I'm going to hold with 4/9/08, unless you have something to be definitive. I'm not going to be --

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BY MR. BUHR:
Q. And the plan there is excision of the mesh, right?
A. Correct.
Q. And you're not aware of any excision of the mesh at that time, in April of 2008?
A. I'm not aware of any, no.
Q. And this is written by Dr. Kim's physician assistant; is that right?
A. I don't know whose assistant it is, but it's a physician assistant.
MR. BUHR: Did we mark Exhibit-8?
MS. GRIFFIN: We did, yes.
BY MR. BUHR:
Q. And you see, Doctor, at the top there, how it lists typewritten, 1/19/2009?
A. Sure.
Q. So just keep that in mind and let me know in a minute if the timing of January 19th, 2009 makes more sense with the subsequent reports by Ms. -- by

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Dr. Kim.
A. Well --
Q. And so, specifically, on -- go ahead.
A. I'm sorry, I did interrupt you. That was my fault. My bad.
Q. So specifically on January 16th, 2009 she returned to see Dr. Kim, right?
A. Yes.
Q. And even according to your report, it says, With a new complaint of vaginal mesh exposure beginning roughly one month prior.
A. Yeah, that's what -- yeah, I must have gotten that from the records.
Q. Right. So this is what she's reporting to Dr. Kim on January 16th, 2009. And you even quote, in your report, About a month ago, her husband noticed some evidence of mesh during sexual intercourse, and this is becoming progressively worse.
Is that right?

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A. Yeah. That's what the report says, yes.
Q. And if you actually look at that report, which is at -- again, it's on Exhibit-5, Bates number ending in 07.
Do you have Bates number 7 in front of you?
A. Yes, I do.
Q. So there in that first paragraph is the language that's quoted in your report that I just read.
And the subsequent sentence says, The patient states that up until a month ago, she did not feel anything at all.
Do you see that?
A. Yes.
Q. So would you agree that that conflicts with the suggestion that the prior report, from Dr. Wyndham, was on January -- sorry. Let me start over.
Would you agree that that conflicts with the suggestion that the report from Dr. Wyndham was April 9th,

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2008, where she had a plan of mesh excision?
MS. SCARCELLO: Objection to form.
THE WITNESS: Yeah, there's a conflict there.
First of all, this is not to be picky, it's a physician assistant, so it's not a physician.
But, yeah, there is -- there is a discrepancy as far as the dates go. I won't argue with that.
BY MR. BUHR:
Q. So at least according to Dr. Kim's report, she did not feel anything until about a month prior to this January 16th, 2009 report, correct?
A. Correct, that's what Dr. Kim reports.
Q. And then Dr. Kim recommended mesh excision, which took place a few days later on January 20th, 2009?

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A. Correct.
Q. And had she stopped using her Estrace cream at this point?
A. I believe I saw a mention of that.
Q. Can that increase your risk for mesh extrusion?
A. Well, I'm not aware of anywhere it states that with the Avaulta product you have to be on it permanently.
Estrogen can potentially help reduce that risk. But, again, I'm not -- I've never seen where you're supposed to be on it.
Q. No. But Dr. Kim had prescribed estrogen cream following the implant, correct?
A. Correct. And it's not uncommon for women not to like it for some reason, concerns about breast cancer, blood clots and those types of things, to stop taking -- or it's just plain messy. But he did prescribe it afterwards.

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Q. And having a hysterectomy at the same time, would she have had postmenopausal changes after the surgery?
A. No.
Q. Was she found to have vaginal atrophy and thinning tissue?
A. Yes. But she still has her ovaries in place. They were not removed, by her request. So we don't know the volume of estrogen being produced. A 49-year-old female, you don't know.
Q. But Dr. Kim recommended restarting the Estrace cream on January 16th, 2009, based on her complaints; is that right?
A. Yeah. As I have in my -- on Page 13, third paragraph, Dr. Kim recommended restarting Estrace cream. But because of the extent of the erosion, I think this needs to be treated surgically, end quote.
Q. Are there factors that can increase a woman's risk for having mesh extrusion?

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A. I've never read in the IFU factors, which if they are known, they should be in there.
I have seen internal documents that if you have a hysterectomy at the same time, you're increasing your risk for exposure. But, again, that's not in the IFU.
Advanced age probably would increase it. But, again, that's not in the IFU. And presence of an infection would do it.
So there are going to be factors there. But I'm not aware of the company disclosing that they knew of factors. If they did, they should report it.
Q. Well, there's also certain factors that are generally known in the medical community.
For example, would you agree that smoking can increase the risk of extrusion?
A. Excellent point. No. If

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smoking were a risk factor, then that has to be in the IFU, and it's nowhere. At least I haven't seen it. We can pull it out and show it, and I'll change my opinion. But I'm not aware of that.
In fact, some will say the mesh kits are better because a smoker has a chronic cough, so it needs to be a stronger repair. So I'd have to -- I'd have to disagree with you.
Q. I guess my question is more that smoking can have an effect on a patient's tissue quality, right?
A. Yes.
Q. And if a patient has poor tissue quality, that can increase their likelihood for something like extrusion; is that right?
A. I suppose, in theory, that is possible.
As far as I know, Ms. Smith is a nonsmoker, so it's a moot point here. But, again, if meshes have an increased risk of complication like

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exposure with smoking, then that's got to be on the IFU.
Q. Turning more specifically to Ms. Smith, if she has thinning of the vaginal tissue and vaginal atrophy, can that increase her risk for extrusion?
A. Well, we're talking theoretically here. But the presence of the mesh inside of her body will cause thinning of the vaginal tissue and atrophy appearance, because it is slowly causing a necrosis. So you can't say which comes first.
She's, at this point in time, a 49-year-old female. Theoretically, she should be producing estrogen still. Her ovaries are still in place. So I can't completely agree with you on what's coming first.
Prior to her surgery, there was -- one year prior, there was no indication of vaginal atrophy. Then she has surgery, a mesh is put in with foreign body reaction, inflammation,

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she's getting exposure, which means thinning out. So I would say a logical conclusion, that's due to the presence of the mesh, not due to her.

Q. I think my question was, if a patient has vaginal atrophy, can that increase their risk for extrusion?

A. I know -- I hear what you're saying.

And not to be difficult, we're talking about a theoretical patient, how severe that is, and we're not talking about Ms. Smith.

So we would have to have a specific individual we're talking about how bad this atrophy is. And, again, let's say you are correct, then that's not on the IFU and it's not warned at all. So if that is a known risk, that will be very important to know.

Q. And so are you agreeing with me that it's a factor to consider?

A. Vaginal atrophy would be, definitely, something that you would want

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to consider if it's severe prior to putting in a mesh.

You don't have to worry about that with nonmesh repairs. But in a mesh repair, you would. And it would be a woman's right to know that her body could be permanently harmed if this product is put in. So, for me, it becomes under a woman's rights issue.

Q. Did you consider vaginal atrophy in your differential diagnosis?

A. Yes, I did. By the reasons I have already explained in the last couple of questions ago; 49 year old, she was 48, I believe, at the time of her surgery, she was premenopausal, her ovaries are still in, there's no vaginal atrophy prior to her surgery.

One year later, with her ovaries still in place, we have mesh exposure, thinning and atrophy. And in my opinion, based upon my experience, vaginal atrophy due to menopause takes years and years to develop, it's not

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going to happen in over one year's time. So, then, the culprit becomes the presence of the Avaulta and the inflammatory process it causes.

Q. In the list of examples of your differential diagnosis on Page 4 and 5, you do not list vaginal atrophy or postmenopausal changes in that list; is that right?

A. It is not listed there, no.

Q. In the excision procedure performed by Dr. Kim, she was able to remove the exposed mesh quite easily, right?

A. Yes, she uses those words, "quite easily."

Q. And I believe you said earlier that this extrusion relates to the Avaulta and not the Align; is that right?

A. I'd have to go back and look at the specific operative note. But, as I recall, this is specifically due to the Avaulta, where it is located. It was

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well away from the Align.

Q. And she healed well following this procedure; is that right?

A. Correct.

Q. The anterior vaginal wall completely healed?

A. Yes. As of the note, April 16th, 2009, I believe she uses that word, The anterior vaginal wall has healed up completely. I do not feel any mesh exposure -- extrusion. End quote.

Q. And Dr. Kim prescribed Vagifem tablets on that date?

A. I did not make a record of that. I would have to see the record.

Q. I think it's the first page on Exhibit-5.

A. He gave -- she gave Ms. Smith samples of Vagifem. So she didn't give a prescription, she gave some samples.

Q. And what is Vagifem, for the record?

A. Vagifems are actually

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estrogen tablets that go into the vagina. They are usually, for most patients, easier to use. They are cleaner. The Premarin cream tends to be quite messy, has an applicator that women don't like.

So Vagifem is just an easier way to insert the estrogen. The problem with it is, it doesn't necessarily stay where you want it to go. But just think of it as a different form of estrogen.

Q. And do you have an understanding as to why Dr. Kim was prescribing estrogen at this time?

MS. SCARCELLO: Object to form.

You can answer.

THE WITNESS: Trying to heal up the vaginal wall or continue to heal it up.

BY MR. BUHR:

Q. Is that something that is needed in order to heal the vaginal wall?

A. Not necessarily, but she was having trouble with the Estrace cream, it

Page 91

was causing irritation. So that could be part of the reason why she stopped it before.

Q. And Dr. Kim obviously felt like it was important for her to have some estrogen cream or estrogen tablets?

A. That would be the standard party line of what you do after a mesh exposure, is to give vaginal estrogen.

But, again, some women can't tolerate it, for multiple different reasons. And if she had trouble with the Estrace cream, which is just a form of Premarin cream, she could also have trouble with the Vagifem, because, it's, again, the same thing, it's just estrogen.

Q. And would you agree at this point in the records there's no documented complaint of pelvic pain or dyspareunia?

A. For her, Ms. Smith, there was no documented pelvic pain or dyspareunia. Her partner had noticed

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discomfort prior.

Q. And would you agree that the -- she did not complain to a doctor about any problems after this until 2017?

A. I did not have anything in the records from 2009 until March 21, 2017. So I agree with you.

Q. And, in fact, during that period of time, she saw Ms. Hoth for her annual exams and reported no complaints of dyspareunia; is that right?

A. That is correct.

Q. You reference an August 8th, 2013 record from Ms. Hoth where she had bothersome arm pain but no other complaints on that day.

A. That is correct.

Q. Did you see that Ms. Smith actually asked Ms. Hoth on that day about advertisements for vaginal mesh litigation?

A. I remember seeing a reference about that somewhere. I don't -- I'd have to see the specific

Page 93

note.

MR. BUHR: Let's attach as, I believe it's Exhibit-9 we're on now, the record from Ms. Hoth on February 16th -- actually, no. Let's attach the record from August 8th, 2013.

- - -

(Whereupon, Exhibit Elliott-9, 8/8/13 Hoth Note, was marked for identification.)

- - -

THE WITNESS: I have it.

BY MR. BUHR:

Q. And if you'd go to the Bates number that ends in 08.

A. Okay. I'm there.

Q. The top of the next page.

But has no other complaints today. Although has a mesh and is concerned about this, given the current TV ads for, Do you have a mesh, you could be due compensation. Has had sling and had mesh put in when she had the

Page 94

hysterectomy. And then they had to trim it up.
Do you see that?
A. Yes, I do.
Q. So she was specifically asking her doctor about concerns about the mesh, but at this point she was not complaining of any symptoms of pelvic pain or dyspareunia or extrusion or anything like that, right?
A. You are correct.
Q. Just to be clear, your report includes a reference to a February 16th, 2012 report?
A. Yes.
Q. Where you have a reference to pelvic pain with exercise.
A. Correct.
Q. You're not offering an opinion that that pain is anywhere related to the mesh at this point; is that right?
A. I'm just stating what the records stated. The record,

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unfortunately, and what I deal with all the time, is incomplete. It just makes a reference to it.
So I put it down as documentation. But I'm not making a conclusion at that point in time.
Q. So at what point in time are you making a conclusion that she's having pain related to the mesh? Is that in March 2017?
A. Well, I have to go off of the records. All I saw in there, and we can maybe go to that February 16th, 2012 note, if it's there, and that was just in there. That's all it stated.
If it stated more, like it's lifting or a pelvic exam confirms it -- I'm just stating that it is there for completeness sake. But I'm not stating that is due to mesh. All I've got is a statement there. That's all I've got.
So, like, for a differential diagnosis, I don't have enough information to make a conclusion. I'm

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just documenting that that's what's in the records.
Q. Okay. Fair enough.
MR. BUHR: And let's for completeness just go ahead and attach that record as Exhibit-10.
- - -
(Whereupon, Exhibit Elliott-10, 2/16/12 Hoth Office Visit, was marked for identification.)
- - -
BY MR. BUHR:
Q. Do you have that in front of you now, Doctor?
A. Yes. The first page is 2017, so it must be before that.
Q. I think that's the printing date.
If you look on the left side, it should be 2/16/2012 office visit with Ms. Hoth.
A. I have February 16th of '12. Is that --

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Q. Yes.
A. Yes, I have it then.
Q. So towards the bottom of that page, it says, Is pain an issue needing to be addressed today? And it says, No.
Right?
A. Yeah, that's what it states.
Q. And then on Bates number ending in 225, about halfway down the page, it has a list for dyspareunia and then it says no.
Do you see that?
A. Correct, that's what it states.
Q. And then a little bit further down is what I believe you were referring to in your record, under musculoskeletal, where she says, Pelvis with exercise hurts and put back out this Christmas.
Is that what you were referring to in your report?
A. Correct.

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Q. And then if you go onto the next page -- well, she does -- she does an exam?
A. Correct.
- - -
(Whereupon, a discussion off the record occurred.)
- - -
BY MR. BUHR:
Q. And her assessment for the GYN assessment is normal exam, correct?
A. Correct. Note, With fullness, no masses or tenderness. A negative exam.
Q. So then at this point, it's pretty clear she is not complaining of any pain or dyspareunia related to the mesh, correct?
A. Well, as before, she has pelvic -- quote/unquote, Pelvis with exercise hurts and puts -- and put back out this Christmas.
So, again, I am not stating it's due to the mesh. I'm not

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eliminating mesh as an option. I'm not including it. It's just a statement that's there.
But in the physical exam, there was no pain on exam.
Q. So, then, in March of 2017, as we've discussed, is her first real complaint of pelvic pain and dyspareunia related to the mesh.
And she saw a doctor -- or, sorry, a nurse practitioner, Shawn Cool; is that right?
A. Correct.
Q. And this doctor also -- or this nurse practitioner also advised on starting vaginal estrogen cream; is that right?
A. Correct.
Q. And why would she prescribe that at the time?
A. Well, I can't speak for this individual, a nurse practitioner. It's pretty much the standard thing, knee-jerk response, to give estrogen.

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It's not going to change pain. It's for a vaginal extrusion. So I can't vouch for the correctness of that decision.
Q. And you state in your report, Said will trial for two months and see if it provides relief.
A. Correct. And vaginal estrogen in two months is not going to do any good, you need much longer than that.
So that's, reading between the lines, somebody who doesn't deal with meshes. It's not a criticism.
Q. She had no -- sorry?
A. I interrupted.
Q. She had no evidence of mesh extrusion at this time; is that right?
A. All I have down is, on Page 14, during the vaginal exam, Ms. Cool noted that the, quote, bladder sling palpable anteriorly during bimanual exam, end quote.
So there's -- I don't know what that means. Is that exposure or

Page 101

what? We can't put a lot into that, because this is a nurse practitioner not experienced in this.
So I can't say, is that exposure? Is that just that you could feel the scarring and the contraction? I put that in there for thoroughness sake.
She needs -- the patient, Ms. Smith, needs somebody more advanced to be able to give us specifics if we want accuracy.
Q. Do you know if she continued using the estrogen cream?
A. I don't recall. I remember -- I know she's used it on and off. But, again, she had vaginal irritation with it, so I don't -- I can't say how well she used it.
Q. In terms of your differential with respect to dyspareunia and the pelvic pain, did you consider the vaginal atrophy that she was having at this point?
A. Yeah. Vaginal atrophy will

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cause diffuse -- can cause diffuse irritation of the vagina, thinning of the vagina. It's not going to cause specific pinpoint pain or palpation of a mesh causing pain.

It can cause some burning with sexual activity. It does not cause, usually, discomfort with normal, daily activities.

So that is always in the differential diagnosis. I ruled it out in this one, again, because the suspicion on exam of palpating the sling.

Q. Are you saying that vaginal atrophy isn't playing any type of role here?

A. It can be a very mild complicating factor. If vaginal atrophy is the source for the problem, estrogen can help repair it. But it's not going to cause pain along a mesh.

Q. But you can't rule it out completely as a mild complicating factor?

A. I can rule it out 99.9

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percent, based upon my experience, my attendance at national/international meetings, giving lectures on the subject, and daily exposure to patients.

Q. Did she have a rectocele at this point? Well, let me rephrase that.

She had a mild rectocele at the time of the implant; had the rectocele progressed?

A. I'd have to go over -- the notes are classic for a general practitioner family practice-type, but they don't give specifics.

The first note with the nurse practitioner, in March of '17, does not tell me anything of specifics of concurrent prolapse.

Follow-up note with the same practitioner, August 13th, 2018, does not state of the posterior -- it does not state of any prolapse, which is an incomplete note and not acceptable with advanced-level-of-care individual.

And the physical exam by Dr.

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Denam, Mary Denam, on -- unfortunately, I don't think I have a date here on this one. Page 15, starting with the bottom paragraph -- for some reason I don't have a date on that, there needs to be a date -- there's no mention of a posterior prolapse.

MR. BUHR: We've been going for a while, Doctor. How about we take a five-minute break and then come back and finish up with the rest?

THE WITNESS: I'm good, if you want to keep going.

MR. BUHR: I'd like a five-minute break, if you don't mind.

THE WITNESS: That's no problem.

VIDEO TECHNICIAN: We're going off record. The time is 3:14.

- - -

(Whereupon, a brief recess

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was taken.)

- - -

VIDEO TECHNICIAN: We're going back on the record. Beginning of Media File 2. The time is 3:24.

BY MR. BUHR:

Q. I'd like to attach some of the records from The Oregon Clinic as Exhibit-11, I believe. These are the Bates numbers that end in 7 -- well, sorry, from 11 to 22.

- - -

(Whereupon, Exhibit Elliott-11, The Oregon Clinic Records, was marked for identification.)

- - -

THE WITNESS: Okay, I have it.

BY MR. BUHR:

Q. If you go to Bates number that ends in 17, it should be an office visit with Lindsey Waugh, if I'm

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pronouncing that correctly, dated August 23rd, 2018.
A. Okay. I'm there.
Q. And this is one of the reports that you reference in -- or one of the records you reference in your report on Page 15; is that right?
A. That is correct.
Q. And it states at this point that she's having a constant, dull pain with intercourse?
A. Well, constant, dull pain, especially with intercourse.
Q. And it notes that the pain level is 2 on a scale of 1 to 10.
Would you agree with me that that's not severe pain that you describe in your report?
A. Well, on a scale of 1 to 10, it doesn't rank up as severe. It's worse than a 1, but it is not in the highest scores, obviously.
Q. And then in the third paragraph on that page, it says, The

Page 107

sling is working great, no leaking.
So her stress urinary incontinence has still been corrected by the Align product, right?
A. That is correct.
Q. Do you see the note that says, Does not use estrogen cream on a regular basis?
A. Correct.
Q. And this is despite being prescribed estrogen cream the prior year by Nurse Practitioner Cool, right?
A. That is correct.
The vaginal estrogen would be for the health of the vaginal tissue, for lubrication during sexual activity. And so it states, And does not have issues with vaginal lubrication.
So the only reason to give her -- or for her to take it would be for a mesh complication. And she's not having exposure, so there's really no reason to be on it.
But that's what it states,

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she does not use it despite what was given to her.
Q. And if you can turn to the notes of physical exam on Bates number 21.
A. Okay. I'm there.
Q. So the external genitalia, it notes, Postmenopausal with moderate atrophy; is that right?
A. Correct.
Q. And then, actually, inside the vagina is postmenopausal atrophic appearance; is that right?
A. That's what it states.
Q. And the estrogen cream would be helpful for that type of atrophy, would you agree with that?
A. If she's making the right call that it's due to atrophy, that would theoretically help, if she can tolerate it.
Q. And then it notes, The posterior compartment prolapse to level of the hymenal ring.

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A. Correct.
Q. What stage prolapse is that?
A. Stage 2.
Q. It's a stage 2 rectocele she has now, right?
A. Correct. It's to the level of the hymenal ring. It doesn't say it goes beyond. That would be a stage 2.
Q. And under impression it notes that she has symptomatic posterior compartment prolapse.
What symptoms was she having related to that prolapse?
A. Well, from the note, she denies feeling a vaginal bulge. She does feel some pressure towards her rectum.
So that would be the posterior prolapse symptoms.
Q. Can posterior prolapse cause pelvic pain and dyspareunia?
A. It can cause a sense of fullness and pressure, but it would not cause a tender-to-palpation issue like she had on her exam.

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Q. And that rectocele hasn't been repaired at any time subsequent to this; is that right?
A. I have not reviewed any records stating that it has been repaired, correct.
Q. So she would still be expected to have symptoms related to that posterior prolapse, right?
A. Prolapse symptoms tend not to go away, so I would expect for her to still have symptoms.
Q. And even though she states that she doesn't believe she has any trouble with lubrication, vaginal atrophy can cause painful sex, right?
A. It can cause irritation and burning with sexual activity, which is usually treated with a lubricant -- or can be successfully treated with lubricant or the vaginal estrogen.
But, again, it won't cause tender-to-palpation or specific pinpoint pain.

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Q. There is no evidence of mesh extrusion at this visit, right?
A. There is no report of mesh exposure.
Q. And then she's referred to Denman.
And I think that's what you were referring to prior to our break?
A. Correct.
Q. And that's when Dr. Denman notes that she has pelvic pain with intercourse and feels a bulge with and after a bowel movement, right?
A. Correct.
Q. And so could some of that be related to her rectocele?
A. That's why you would need the physical exam to confirm it. A physical exam will tell you if she has the rectocele, palpation in certain areas, pelvic floor, et cetera.
Again, that's why the physical exam is so important.
Q. And Dr. Denman even notes

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that she was on vaginal estrogen for a period of time but not long-term --
A. Correct.
Q. -- correct?
A. Yes.
Q. And she has not had any pelvic floor physical therapy?
A. Correct.
Q. Is that something that can help with pelvic pain?
A. It depends what type of pelvic pain it is. In my experience, pelvic floor myalgia which is de novo, you can have some benefit from it.
Secondary to mesh, I have never had a patient get significant reduction of pain with physical therapy.
Q. Would you agree that Dr. Denman felt that physical therapy was an important part of her plan for Ms. Smith?
A. Well, not really, because she recommended going to surgery fairly soon afterwards. So it was not a serious consideration. She gives it as an

Page 113

option.
Q. Let's turn to Dr. Denman's report from August 29th, 2018, which is actually part of that last exhibit.
Do you have that record in front of you?
A. Yes, I do. You're talking Exhibit-11?
MS. GRIFFIN: Correct.
MR. BUHR: Yes.
THE WITNESS: And what page -- I'm sorry, Bates number?
MR. BUHR: The Bates number 11. So the first page of that exhibit.
THE WITNESS: I'm there.
BY MR. BUHR:
Q. So about halfway through the paragraph, under plan, it says, Discussed need for PT -- which I assume is physical therapy -- after surgery to help decrease scar tissue formation as well as decrease pain.
A. Correct. That's what she

Page 114

states.
Q. Do you agree that that's -- do you agree that that's part of her plan, then, and she thought that would help?
A. Well, she discusses it after surgery. It won't have any bearing on scar tissue, but it may help decrease the pain. In my experience, it does not.
Q. Will it help --
A. I'm sorry.
Q. Would it help decrease the formation of scar tissue after the surgery?
A. No, absolutely not. It has nothing to do with that. Unless she's talking about vaginal dilators to help prevent scarring of the vagina. But physical therapy alone does not help with that.
Q. So you think she's just wrong on this?
A. I didn't say that. The note is not clear.

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Who knows what she's thinking. If she's talking about vaginal dilators, sometimes they'll use various different vaginal procedures and stretching. If they're talking about that physical therapy, yes. But that falls into the pelvic floor rehab.
So I can't state what she's talking about here. And if she's referring to the vaginal dilators, then, yes, that will help reduce the narrowing and aggressive scarring of the vagina.
Q. And Ms. Smith hasn't done any type of PT after the surgery, right?
A. I'm not aware of her doing any, no.
Q. Then she also states, Discussed need for perioperative vaginal estrogen to improve healing.
Do you have any disagreement with that part of the plan?
A. For mesh exposure, I think it probably plays a role. For mesh scarring, mesh arm contraction, it will

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have no benefit.
Q. She refers to the -- her impression -- well, strike that.
You can have vaginal scarring after any type of vaginal procedure; would you agree with that?
A. In varying degrees, severity, progression, permanence, inability to fix, that can happen with procedures.
But, again, there's going to be variables with each procedure.
Q. Right. But it's something that's well known and expected, correct?
A. Well, no. It depends upon who you're talking to, their level of knowledge, their level of experience. And then, again, in varying degrees.
Not all doctors read the same books, attend the same meetings. There's variable --
Q. You agree that Dr. Kim testified that she was aware of the risk of scarring and scarification?

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A. She was aware of what she knew but not the full extent of it, as we've talked about before.
Q. Well, again, you don't know the full extent of what she knows?
A. I don't. I'm playing odds that she has not reviewed what I've reviewed. And she knows what she knows, and I have no argument against that.
Q. But there's expected to be a certain amount of scarring around any type of pelvic mesh that's implanted; would you agree with that?
A. All meshes have been shown to increase fibrosis and scarring. Not all meshes are the same, so there would be varying degrees of mesh scarring with a specific product.
Q. And how do you define banded as you refer to it in your report? Is that related to scarring?
A. That is a function of scarring and the product design. And that's referring to, usually, the mesh

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arms, as when they're pulled through, they roll and contract and cause banding. They are palpable, you can feel it. There's a very classic feel to it.

Q. Here, Dr. Denman advised against removing the arms, she doesn't feel there's any problems related to the arms.

Would you agree with that?

A. No, I disagree -- I mean, I agree not to remove the arms, that is a risky, dangerous surgery without any clear benefit.

Now, some surgeons around the United States still do that, or are trying to do it. We still don't know if that's the right way to go. I personally do not remove the arms. Again, it's a very, very difficult, morbid procedure with the risk/benefit ratio more on the risk.

So it's not that Dr. Denman didn't think that was the source of the problem, she didn't feel that it would

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cure the problem.

Q. Well, did you read her deposition testimony where she specifically testified that there was no pain at the arms of the mesh?

A. Correct.

Q. And do you have any reason to disagree with that assessment?

A. Based upon the physical exam at that point in time, she touched the right area, I have no reason to doubt it.

Q. So there's no evidence that she has pain related to the arms of the mesh, right?

A. Well, she had -- she was tender to palpation and she had the thick banding on the anterior wall painful to palpation, 2 centimeters in width at max with lateral arms obturator. So that, to me, tells it's -- the arms are a component to this.

Q. But she specifically testified there was no pain at the arms of the mesh?

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A. I'm just going off of what her note is here. And it seems pretty clear here. Again, thick banding anterior wall painful to palpation, approximately 2 centimeters in width at max with lateral arms, question mark, obturator.

And so I don't know -- we'd have to look at her exact testimony, which may be helpful. But this, to me, seems pretty clear.

But, again, if I were her in her situation, I would not go after removing those mesh arms.

Q. Let's look at her deposition testimony. If you can hand him Dr. Denman's transcript from June 13th, 2019.

MS. GRIFFIN: I'm sorry, Eric, that came in spotty. But we will mark Dr. Denman's deposition testimony from June 13th, 2019. And that will be Exhibit-12.

- - -

(Whereupon, Exhibit

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Elliott-12, 6/13/19 Deposition Testimony of Dr. Mary Denman, was marked for identification.)

- - -

THE WITNESS: Okay, I have it.

BY MR. BUHR:

Q. If you'd go to Page 79.

A. You cut out.

Q. If you'd go to Page 79.

A. Oh, 79.

Q. And this is the individual page number. Because on Page -- because there's four pages per page.

A. Sure. I'm there.

Q. So Page 79, Line 5: So going back to the plan on Page 11, it states here that you didn't find any issues with the arms of the mesh; is that right?

Denman responds: Correct.

And then further down, Line 14: And when you say there were no issues, that's because on examination it

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was not tender there, right?
Her answer is: Correct.
She was not reporting pain there, right?
She responds: Correct.
So would you agree, then, that she wasn't having any pain at the site of the arms?
A. That's what she states. I'm just going off -- we have a discrepancy between her that-day exam and then what she testifies, you know, a year or so later.
But that's what she states. There's a discrepancy here.
Q. Right. Her sworn testimony as she's reviewing her records.
A. Correct, that's what she states.
Q. Are you going to disagree with her assessment?
A. No, that's what she states under oath. I have no reason to disagree. I was just going off of the

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physical exam at the time. But, you know, that's what she states later.
Q. Dr. Denman, in her report, there's a reference to that she discussed likely nerve damage from FAVD, which I believe is forceps-assisted vaginal delivery; is that right?
A. Yes. I would assume so. That's not an abbreviation -- I don't do any OB, so I assume that.
Q. Then it goes on, Episiotomy with delivery. Reassurance there's not a mesh factor involved with this issue, speaking of the fecal incontinence.
And you don't have any disagreement with that, do you?
A. No. A vaginal delivery and episiotomy and, I believe, she had four or five, maybe even six children, which were all decent-sized babies, that, logically, is going to cause fecal incontinence. And it is -- in my opinion, the Avaulta and Align are not associated with fecal incontinence.

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Q. Excuse me for a second.
Are there any more conservative options Dr. Denman should consider before removing the mesh?
A. No. Dr. Denman did a nice job.
Your two options, which we still do not know, I don't know, even though I see this every day, is, what do you do with these individuals? Do you operate or let them be? And then if you do operate, how aggressive do you get? It still remains to be defined.
So I think she did a nice job. She felt this -- she felt the mesh, so she felt surgery to get rid of the mesh was a viable option. So I have no criticism. I think she did a nice job.
Q. Ms. Smith wasn't on any pain medications at this point, was she?
A. No, she was not.
Q. And she had not done any physical therapy, correct?
A. I am not aware of her doing

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any physical therapy.
Q. And she was periodically on estrogen but not consistently, correct?
A. Correct. As I stated before, it won't help with mesh-related pain. But you are correct, she took it intermittently.
Q. Can trigger point injections help pelvic pain like this?
A. Due to the mesh, no. Due to pelvic floor myalgia muscle spasms, they may play a role and have shown some success.
Q. Then they proceeded to the explant on November 15th, 2018.
A. Okay.
Q. And she was noted to have moderate scarring; is that right?
A. That is what she states, Moderate scarring of contracted mesh at the level of the trigone/UBJ.
Q. And, again, you're going to have scarring with any type of vaginal mesh procedure, right?

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A. In varying degrees, dependent upon the specific mesh, you will have some.
Q. It notes that she removed, quote, blue mesh; is that right?
Do you see that?
A. Yes. She makes a specific -- midline blue mesh was noted, meaning that in the middle of that, there was some that was blue.
Q. And you would agree with me that that would be the Avaulta mesh?
A. That is correct.
Q. And Dr. Denman noted that the tissue was really thin, the vaginal tissue.
Is that possibly due to not using estrogen cream consistently?
A. It's due to the presence of the mesh causing chronic inflammation and pending erosion -- excuse me, exposure. And there's granulation tissue, meaning poor healing.
Q. Every patient heals

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differently, would you agree with that?
A. Well, no. I mean, there can be certain patient factors that can slow it down or speed it up. There can be variations there.
Q. And what patient factors -- what patient factors are those?
A. Chronic steroid use, perhaps; markedly advanced age, perhaps.
But we're talking with -- the vagina is different than with abdominal procedures. So the vaginal estrogen content would probably be one.
But the presence, also, of a foreign body in there is the main factor.
Q. And vaginal atrophy can be a factor.
But if I understand your testimony right, you believe that vaginal atrophy itself was caused by the mesh in some fashion?
A. Well, I'm saying that's a contributing factor, a major contributing factor.

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If vaginal atrophy, just using logic here, were a major aspect of poor vaginal healing, then all of the hundreds of transvaginal repairs I do without a foreign body would also be breaking down and having exposure, and they're not. I don't get any, zero.
We watch our patients very closely with questionnaires, telephone follow-ups, seeing them back in clinic, wound breakdowns in the vagina.
With meshes, you know, there is the known risk of the granulation tissue -- granulation tissue, poor healing, inflammatory process.
So I'm saying in Ms. Smith, looking at all the factors, the presence of the foreign bodies and the inflammation is causing her thin tissue breaking down and the scarring is causing the pain.
Q. But would you agree with me that not every patient that has transvaginal mesh results in vaginal

Page 129

atrophy and thinning of the vaginal wall?
A. You are correct. Not every patient has bad outcomes like Ms. Smith.
Q. Right. So in some fashion, it's a patient factor?
A. Well, no, I disagree with that. I mean, if there's a known risk factor that we can point at in Ms. Smith that the Bard people know about, then it's got to be in the IFU. But there's nothing in there.
They have some contraindications, I believe, it's just for pregnancy, bleeding problems. But that's it. So to blame her is to be blaming, what, 20, 30 percent of the patients who have Avaulta? So I don't think that's right. I don't have any logic to go off of for that.
Q. The fact is that some patients have complications from surgeries and some patients don't?
A. That is a fact, yes.
Q. Right?

Page 130

A. Correct.
Q. So, then, after the procedure -- well, first, let me confirm, the Align sling is still performing as intended in correcting the stress urinary incontinence, correct?
A. From everything I know at this point, you are correct.
Q. And I believe her last -- well, let's look at your report.
You reference a visit with Dr. Denman on December 3rd, 2018 on Page 17 of your report.
A. Correct.
Q. And I think that might be an incorrect date.
MR. BUHR: Let's attach as Exhibit-12 the report from Dr. Denman, January 2nd, 2019.
MS. GRIFFIN: Okay. We will be attaching this as Exhibit-13.
- - -
(Whereupon, Exhibit Elliott-13, 1/2/19 Dr. Mary Denman

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Report, was marked for identification.)
- - -
THE WITNESS: Okay, I have it.
BY MR. BUHR:
Q. So not that it's a controversial issue, but just for the accuracy of the report, what you reference here as December 3rd, 2018 appears to be from this January 1st -- I might be corrected.
A. I think it's correct. If we look at Bates Number 32, that's 12 -- it's, what, two pages in? 12/3/18, first post-op exhibit. Then if you go to Page 33, exam, vaginal incision. And then that's less than 5 centimeters separation. So I think that date is correct.
Q. You're right.
In your report, you don't have the January 2nd, 2019 report, right?
A. That is correct, yes.

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Q. Okay. So for the December 3rd, you have a, quote, Small area of midline granulation tissue.
Well, actually, I think the quote is that there was a separation along the incision with good granulation tissue.
Do you see that on Page 33?
A. Yes, I do. I -- yeah, so the December 3rd quote -- well, there's not a quote. It says, Small separation of vaginal incision measuring less than .5 centimeters.
And then I do quote the follow-up visit on January 2nd, that's what you were referring to. But I don't see the physical exam on that one.
Q. Okay. We'll just -- that makes sense. Sticking with Page 33.
Do you know what she means by "good granulation tissue"? What does that mean to you as a doctor?
A. This is a fresh post-op. This is two weeks after surgery. You

Page 133

expect to see granulation tissue there.
It just means that it's in the very early healing periods. It's healing appropriately.
Q. And it was nontender to palpation on December 3rd, 2018?
A. That is correct.
Q. And then going to January 2nd, 2019, which is the last report we have -- is that right? This is the last report we have from the doctor?
A. That's the last that I have, yes.
Q. And her vaginal exam is nontender?
A. Correct.
Q. And there's a small area of midline granulation tissue?
A. Correct. That's in my report and on this -- from this date.
Q. And she prescribes estrogen again for her?
A. I don't know if she prescribed it. But it states, Estrace to

Page 134

vagina, which would be an estrogen cream.
Q. And that would be to help with the healing?
A. Correct.
Q. And she okays her for intercourse after two weeks.
Do you have any criticism of that, based on what the exam showed?
A. I personally would wait until it's completely, 100 percent, healed up. So I don't go by a date. Six weeks out is usual timeframe. And so she's postponing it another two weeks.
So Dr. Denman's assessment was that it would be safe at that point in time.
Q. But she doesn't examine her and confirm that the healing is complete before authorizing intercourse; is that fair?
A. I do not see that in the records anywhere.
Q. And if Ms. Smith had vaginal intercourse before the -- her vaginal

Page 135

wall had completely healed, could that contribute to continued problems healing?
MS. SCARCELLO: Objection.
You can answer.
THE WITNESS: Well, I would need to know -- I mean, we're talking in theory here.
With this small area of midline granulation tissue, I don't know how extensive that is. I feel that Dr. Denman, in her experience, must have felt it was mild. And then two weeks would have been safe.
If she went -- preceded those two weeks, or within that two weeks had intercourse, that might not be the ideal. If she waited until afterwards, Dr. Denman felt it was safe.
BY MR. BUHR:
Q. Thank you. But I think my question was, if you have sexual intercourse before the vaginal wall is

Page 136

completely healed, can that contribute to continued healing problems?
MS. SCARCELLO: Same objection.
THE WITNESS: I would agree with you. It's definitely not going to help.
BY MR. BUHR:
Q. And you, in your report, are offering certain opinions about Ms. Smith's likely prognosis; is that right?
A. That is correct.
Q. And you describe her prognosis as poor?
A. That is correct.
Q. And you wrote this report before reading Dr. Denman's testimony; is that right?
A. That is -- yes, that is correct.
Q. And Dr. Denman testified that her pain and dyspareunia is markedly improved since the 2018 surgery; is that right?

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A. That is correct.
And that is also my experience on early post-ops after meshes. You usually have a period that the pain is less and it comes back, in my experience, and in the experience of individuals who have written papers on this subject.
I hope it doesn't, but it usually comes back.
Q. So are you saying -- are you offering an opinion, to a reasonable degree of medical certainty, that her pain is going to return?
A. Based upon my experience, my attendance at national/international meetings and my giving lectures on the subject, my dealing with patients, and I've operated on these types of patients, that the odds are greatly that pain will come back.
Q. So can you state, with a reasonable degree of medical certainty, that the pain will come back?

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A. Just as I already stated, with all those aforementioned criteria, that pain usually does come back.

And that's why I have chosen to stop operating for these conditions for pain. And that's also based upon a paper by Ho, et al., H-O, et al., where the poor success of operating for pain, because it doesn't work.

Q. But you would at least agree that at this point it's markedly improved?

A. Correct. And that is wonderful. And I hope I'm wrong. And if I'm wrong, that's wonderful for Ms. Smith.

I just -- in my experience, it doesn't last.

Q. So it may come back but it may not; is that fair?

A. The odds are, based, again, the Ho, et al. -- I believe it's Ho, it's a Zimmerman -- Phillipe, Zimmerman, at UT Southwestern, talks about roughly a 70

Page 139

percent chance that the pain comes back or is not cured by surgery.

Again, if I'm wrong, that would be wonderful for her. But, unfortunately, experience has told me otherwise. I've had many patients. I do surgery on it, and they have great pain relief, and we're thrilled, and then disappointed months later or years later.

Q. In Dr. Denman's testimony, she describes some more -- a more recent visit with Dr. -- I'm sorry, let me start over.

In Dr. Denman's testimony, she discusses a more recent visit with Ms. Smith where she had some lateral muscle pain.

Are you offering any opinion about the cause of that lateral muscle pain?

A. I would have to see that actual report before I could state definitively. Lateral is very worrisome for the arm pain, mesh contraction.

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Q. Did you see Denman's testimony that she could not conclude the cause of it?

A. Yeah, we would have to look at the specific report. I recall her stating that.

Q. And she didn't note any muscle pain prior to the explant in the same area; is that right?

A. Again, we need to look at the specifics. I would be going off of memory, so it wouldn't be fair. I have the report here.

Q. Well, we don't have the report from --

A. I'm sorry, deposition. I'm sorry, you said deposition, I thought.

Q. I think it's on Page 55.

A. Okay. I'm there.

Q. So she was having a little increased pain?

A. Correct. That's what I'm -- that's what I'm describing. In my experience, that fits perfectly.

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You have an initial good response, and then it comes back. Again, I wish I were wrong, but that's what happens.

Q. But do you see how she describes this as muscle pain on Line 9?

A. Correct.

Q. And then says she does not -- she does not know what's causing that muscle pain?

A. Yeah. I agree she doesn't know what's causing it.

Q. So I'm saying, to a reasonable degree of medical certainty, she doesn't know what's causing it, can you state -- you can't state, to a reasonable degree of medical certainty, what's causing it without examining the patient, correct?

A. An exam would be very beneficial. I can state, based upon my experience of doing probably hundreds of these, that she has pain that's coming back. It's in the muscles due to the

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presence of the arms; going through the various different muscles from the obturator foramen bilaterally.

Dr. Denman, no criticism to her at all, doesn't know because she just hasn't done these. This is probably her one and only time she's done this. So I don't criticize her. She doesn't know, she admits it, which is very admirable.

And I'm saying, with a reasonable degree of medical certainty, it's due to the presence of the mesh arms.

Q. If you'd turn to Page 35 of her deposition.

A. Okay, I'm there.

Q. The very last -- Lines 24 and 25, where it says she didn't have any muscle pain, so this was prior to the explant, she didn't have pain in the same area where she's complaining of pain now.

So wouldn't that make it less likely to be related to the mesh?

A. It's a progression of the

Page 143

fibrosis and scarring. They know from animal models, from, like, Closter, Hoffin and others, that the mesh extraction continues indefinitely. They have dog studies 15 years, 20 years out. So this is the natural progression of it.

Q. After the mesh -- the central part of the mesh connecting the arms has been removed?

A. Yes. But the mesh arms are still going through the obturator foramen connected to -- off the top of my head I would say it's six or seven different muscles. So the mesh continues to contract, and you get continued pain.

Q. Does Ms. Smith have back pain, lower back pain?

A. Yes, she does.

Q. Can that radiate into the pelvis area?

A. Not causing specific pinpoint pain. That's where an exam would help sort that out.

But back pain is in the

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back. You can have radiculopathies going down the legs. Again, it just depends upon where this pelvic pain is.

If it's mid vault, is it obturator foramen versus if it's in the low back -- if it's in the low back, I agree with you, it's not due to the mesh.

Q. And we just don't have the detailed descriptions, as we sit here today, to completely rule out pain radiating from her back?

A. Well, I have no medical records describing her back pain and where that pain is and where it radiates to. If we had that, that would help sort out the issue.

I'm saying that when you put all the factors together of having a large volume of mesh put through the obturator foramen, having mesh contraction and pain, removing it, and in my experience, in the literature, 50 to 70 -- 30 to 50 percent mesh arm contraction rate, everything fits as far

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as it being with mesh.

But definitively answering the question would require either an IME or an advanced expert to examine her and telling us otherwise.

Q. But you would agree that the pain is still markedly improved over prior to the explant?

A. I can't say that. She says it's increased. But it's -- there's no indication that it's back to where it was. I forget, we were on Page 35, I believe.

Q. 55.

A. 55.

Q. She describes it as having a little increase in pain.

A. Yeah. So that would imply, to answer your question, yes. As of that -- the last exam, which I don't have the records from that, she states she was having a little increase in pain. You're correct.

Q. Do you have any opinion on

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what future care Ms. Smith may need?
A. In my opinion, the only chance for some improvement would be very aggressive advanced-level physical therapy, biofeedback, bladder retraining; questionable injections into the mesh, around the mesh. In my experience, that has worked very poorly.
The other option is surgery to remove the mesh arms. In my experience, that tends not to work very well and can make the pain worse. There are surgeons around the nation who do go after that. I have just felt the risk outweighs the benefit.
So she has options, none of them are really good options.
Q. That would depend on whether her pain returns and, if so, how much --
A. Correct.
Q. -- right?
A. Correct.
Q. So as of today, you're not offering an opinion that she's going to

Page 147

require any further surgeries; is that fair?
A. I'm saying that I would have to wait and watch with time. If she only now, or whenever this last exam was, has a little increase in pain, then she should not undergo surgery.
Q. Do you have any opinion as to whether she will require future surgery to repair her rectocele?
A. Well, a rough estimate is that roughly a third of women have their prolapse progress to needing surgery. So that's just a rough idea.
But it would be immaterial to the Avaulta. It's a separate problem.
Q. Right. But further surgeries related to -- for an unrelated rectocele could result in more pelvic pain and dyspareunia, correct?
A. Well, we're talking, in theory, she could. But she wouldn't have any mesh-related pain. Again, we're talking in theory.

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Right now she doesn't warrant it. So I don't have specifics where I can give an answer to that one.
Q. But, in general, in terms of the known risks of repair of pelvic organ prolapse, it can result in pelvic pain and dyspareunia, right? Even without mesh?
A. You have to put qualifiers on there. There's varying degrees, severity, progression, inability to fix it. But the posterior prolapse can be associated with it. But, again, it's not to the severity that we see with the meshes.
Q. And if she would have had -- one of -- well, let me start over.
One of the safer alternatives that you allege in your report is repair with biologics. And that's both for stress urinary incontinence and pelvic organ prolapse.
But those types of repairs also include the risk of pelvic pain and

Page 149

dyspareunia, right?
A. Not to the degree that we see with the meshes and the severity and the progressive nature of it. So no.
Q. But there's risks and benefits to both of those procedures, right? And the doctor has to make that risk/benefit analysis?
A. If that physician, he or she knows all of the risks known to the company, the severity, the progressive nature of it, and the inability to repair it with the meshes -- again, there's too many variables to give a blanket statement to.
Q. Let me say it this way: Using a biologic -- which, first of all, a biologic is not a similar product; it's a completely different product, right?
A. It is a non-mesh product, yes.
With her situation, biologics would be way down the list. It would just be use of standard absorbable

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sutures that cost $5, would be what I would do with her.
Q. For the treatment of her pelvic organ prolapse?
A. Correct. With the stage 2 anterior prolapse like she had, a standard suture repair of five or six sutures, or less, that cost all of, again, $5, would be what I'd do.
I would not go down the route of biologics. They are theoretically an option. But she had a relatively mild prolapse, so I wouldn't do that. It's an option, but it wouldn't be what I would do.
Q. So, again, that's not utilizing any type of transvaginal mesh, then?
A. Correct.
Q. What about for treatment of stress urinary incontinence?
A. Then you can use her own tissue. You can use tissue from a tissue bank. Then you could use biologics.

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Others are available. Using her own tissue is the easiest and cheapest.
Q. And the use of biologics wouldn't completely eliminate her risk of pelvic pain and dyspareunia, correct?
A. As we mentioned before, I go based upon my previous testimony, depending on the severity, the frequency, the progressive nature of it and the inability to repair it is going to be different with the biologics.
You don't see those problems with it. You see recurrence, but you don't see those other chronic, lifelong problems.
Q. But recurrence is a major consideration in determining what procedure is best for the patient, would you agree?
A. It is a consideration. If you asked the patient, would you rather have a recurrence of your prolapse or lifelong pain and inability to have intercourse, those are two different

Page 152

things.
Q. The main reason the community, medical community, was looking towards polypropylene mesh was to increase -- or, rather, decrease the risk of recurrence, correct?
A. That was the goal, which is an admirable goal. However, it didn't pan out that way. And so the anatomic repair rate was possibly better in the anterior vaginal vault. But apical and posterior, there was no benefit. So the reoperation rate was the same.
So you increase the complications for the woman without giving her a significant benefit.
Q. Plaintiff's implant procedure was in January 2008, right?
A. Correct.
Q. The only safer alternative that you list that's specific to vaginal mesh is a lighter-weight, larger-pore polypropylene mesh, right?
A. Correct.

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Q. And are you aware of a midurethral sling, at that time, that meets the description in your report?
A. Well, I talked about POP repair. I didn't mention anything as far as a sling.
So that Point Number 3 on Page 19 is a POP repair using a lighter-weight, large-pore mesh. So that's not pertinent to the sling.
Q. What about Number 4 on Page 20?
A. Correct. I am not aware of there being an on-the-market, available, a lightweight, large-pore mesh sling. There were trials of them, but they were never released.
Q. But you believe there was a POP, pelvic organ prolapse, mesh that's lighter weight and larger pore --
A. Ethicon had --
Q. -- in 2008?
A. I'm sorry, I interrupted you.

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I cannot specifically state to 2008. Ethicon did have a product that was out there, but didn't have the arms. The arms are what causes a significant component of the problem with pain.

That's what I'm saying, is that this particular patient, Ms. Smith, did not need those advanced-level repairs. It was a first-time surgery with a low-grade prolapse.

Q. And even if there was a lighter-weight, larger-pore mesh available at the time, it wouldn't have eliminated her risk for pelvic pain or dyspareunia or extrusion, correct?

A. Let's break that down. That's a -- what I call a compound question. I don't know what you guys call it.

We have to define the type of mesh we're doing. If all you're doing is a mesh without the arms -- see, the arms are a major source of the problem -- so your risk of extrusion would

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theoretically be the same, as long as it doesn't have the, you know, like the Avaulta Plus has that confounding factor of the extra layer of tissue on it.

And then you said pelvic pain. Pelvic pain may be less because you don't have the arms.

And I think you said a third thing there, I forget what that was. You had three.

Q. Dyspareunia.

A. Dyspareunia. Dyspareunia has a chance of being less when you don't have the arms, because you don't have the mesh contraction and the pulling that you get with those things.

So that would -- I know surgeons who still will put in those grafts without the arms. I personally don't. I don't think there's a need for it.

And, again, in Ms. Smith's situation, she didn't need it. She just needs standard sutures.

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Q. But to answer my question, it wouldn't have eliminated her risk of pelvic pain or dyspareunia or extrusion?

A. Correct. It would lower it, but not eliminate it.

Q. I don't want to retread grounds from your generic deposition, but you're not aware of any more recent literature finding that the Bard mesh, the Avaulta, has a higher risk of any complications as compared to any other transvaginal mesh; is that fair?

A. As I'm sitting here right now, I cannot recall off the top of my head a document such as that. But I would have to look through the literature for it. And since it's been pulled off the market, no one is researching it.

Q. So it's possible, if she had a different pelvic organ prolapse mesh, that she would have had dyspareunia and pelvic pain and extrusion, correct?

MS. SCARCELLO: Object to form.

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THE WITNESS: Well, it depends what we're talking about.

Are we talking about, like, the Prolift? anterior? Are we talking about the Monarc product? Excuse me, not Monarc, American Medical Systems, the Apogee and the Perigee? There's a lot out there. All of them have their known risks to it.

Again, with -- Avaulta is a unique one with having that outer coating to it, which throws in another variable in a situation.

But the risk with all meshes is there in varying degrees.

BY MR. BUHR:

Q. Looking back at the opinions in your report, on Page 18, we talked earlier about Dr. Kim's testimony that she was aware of the risks of erosion, extrusion, pelvic pain, dyspareunia.

You recall that discussion, right?

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A. Yes, I do.
Q. In your report here, you specifically refer to foreign body reaction and chronic inflammatory response related to the Bard products.
A. Correct.
Q. Would you agree that Dr. Kim specifically testified that she was aware of those risks?
A. As I've already stated, she was aware of what she knows, but does not know the full extent of it.
Q. You also reference painful contracture and banding of the mesh.
Would you agree that Dr. Kim testified that she was aware of those risks as well?
A. As I stated previously, and I'll rely on the previous testimony, she stated what she knew, and she doesn't know the full extent, as I do and others involved in this, what's going on behind the scenes with the company.
Q. So I understand that that's

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your testimony, that she didn't know the full extent.
But there's no risks that she wasn't aware of that are relevant for Ms. Smith?
A. She knew about risks. But she didn't know about the severity, the frequency and the progressive nature of those risks.
Q. But she was aware of each of the risks and complications that you're opining Ms. Smith had as a result of the Bard products, right?
A. Well, as I've stated, she knew of risks. But she didn't know of the severity, the frequency, the progressive nature and the inability to fix those complications.
Q. Her anterior prolapse that was corrected by the Avaulta, that has still not returned, correct?
A. Based upon the January 2nd, 2019, so, what, six, seven months ago, there was no record of the prolapse

Page 160

coming back.
Q. So both the Align and the Avaulta corrected the conditions for which they were implanted for, right?
A. At a certain cost, you are correct.
MR. BUHR: That may be all the questions I have. If we can just take a quick break and then come back.
THE WITNESS: Sure.
VIDEO TECHNICIAN: We're going off record. The time is 4:25.
- - -
(Whereupon, a brief recess was taken.)
- - -
VIDEO TECHNICIAN: We're going back on record. Media File Number 3. The time is 4:27.
BY MR. BUHR:
Q. So we talked earlier that Ms. Smith had preexisting depression; is

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that right?
A. She was on medication for depression. I don't know how severe it was.
Q. Can there be a psychological component to dyspareunia?
A. Possibly. However, it's not going to cause pinpoint pain and pain at the site of the mesh. That's not -- that's not a component of depression.
And if depression is a major factor in causing complications with meshes, it needs to be on the IFU, which it's not.
So she had a preexisting condition. And that's worrisome if it's not on the IFU, that worsens things.
Q. Well, I wasn't suggesting that it was relevant to the mesh.
But even without mesh, a patient can have dyspareunia due to psychological issues and depression?
A. Well, that's a broad statement. If there's a history of

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physical trauma, rape, abuse of some sort, that's a different story. That becomes very complicated.

But she reported nothing prior to the surgery. This all happened years later. So I don't see a logical connection between the two.

Q. Because she didn't have similar complaints prior to the implant?

A. Well, the location of the pain, the progressive nature of it, the severity all happen years later. So, again, I don't see a logical connection between the depression and this.

Again, if it is a known issue, that's got to be on the IFU.

Q. Can depression and general wellbeing affect the healing process in an individual?

A. As far as it relates to the vagina, I've never heard of anything related to that.

Q. Have we discussed all the opinions you intend to offer in this

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case?

A. All my opinions are included in my report. I don't recall if we've discussed every one.

We've discussed all the opinions you've asked me. Not to be a smart-mouth about it, but I don't know if there's something else here we haven't discussed.

Q. And at this point, you don't have any intention of performing an examination on Ms. Smith? But you might -- you would like to have the opportunity to do that if the case were to go to trial; is that how I understand your testimony?

MS. SCARCELLO: Object to form.

You can answer.

THE WITNESS: Yes. If this case were to go to trial, then I would have to perform an IME prior, to further support or refute my opinions at this point.

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I'll keep an open mind, based upon what's going on.

And the farther she goes out from her revision surgery, it would be important to have a documented exam, too.

MR. BUHR: All right, Doctor, I think that's all the questions I have today.

MS. SCARCELLO: Nothing from me.

VIDEO TECHNICIAN: This concludes today's --

MR. BUHR: Hold on. Before we go off the record.

I just want to make sure we have a placeholder exhibit for the invoices that will be provided by counsel's office.

- - -

(Whereupon, Exhibit Elliott-14, Placeholder, was marked for identification.)

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MR. BUHR: With that, I think we're done. Thank you.

MS. SCARCELLO: Thank you.

VIDEO TECHNICIAN: This concludes today's deposition. We're going off the record. The time is 4:31.

- - -

(Whereupon, the deposition concluded at 4:31 p.m.)

- - -

CERTIFICATE

I HEREBY CERTIFY that the witness was duly sworn by me and that the deposition is a true record of the testimony given by the witness.

Amanda Maslynsky-Miller
Certified Realtime Reporter
Dated: August 12, 2019

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ACKNOWLEDGMENT OF DEPONENT

I,____________________, do hereby certify that I have read the foregoing pages, 1 - 165, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

____
DANIEL S. ELLIOTT, MD DATE

Subscribed and sworn
to before me this
_____ day of ______________, 20____.

My commission expires:______________

____
Notary Public

LAWYER'S NOTES

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